Date: _____ new patient forms

Name (to be called) _____Name Listed with Insurance (if different):_____
Pronoun_____ Birthdate _____

New Patient Medical Intake Form

This form helps us learn about your medical history. Please complete it to the best of your ability. Not every question is relevant to everyone. If you feel uncomfortable answering a question, leave it blank. We use a harm reduction model of care; therefore, we will never penalize you or deny you care based on what you tell us on this form.

Do you need help with this form? ☐ Yes ☐ No
If you answered yes, please stop filling out the form and speak with a Front Desk staff member.

Person filling out this form (if not the client): _____
Name Relationship to Patient

Medical History

What medical conditions do you have? ☐ None (Skip this section)

- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ High Blood Pressure/Hypertension
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ History of Stroke
- ☐ History of Heart Attack
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Liver Disease_____
- ☐ Pancreatitis
- ☐ Kidney Disease_____
- ☐ Breast Disease_____
- ☐ Thyroid Disease_____
- ☐ Migraines
- ☐ Blood clots
- ☐ Chronic Pain _____
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Autoimmune Disease_____
- ☐ Epilepsy
- ☐ Traumatic Brain Injury
- ☐ Pituitary Adenoma
- ☐ Alzheimer's or Dementia
- ☐ Hearing Impairment
- ☐ Blindness
- ☐ Intersex Condition_____
- ☐ Sleep Apnea
- ☐ Allergies
- ☐ Asthma
- ☐ COPD or Emphysema
- ☐ Tuberculosis (TB)
- ☐ Cancer _____
- ☐ HIV or AIDS
- ☐ HSV (Herpes)
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Incontinence
- ☐ Hemorrhoids
- ☐ Irritable Bowel Syndrome
- ☐ Other medical conditions not listed:

_____

Mental Health History

What mental health conditions do you have? ☐ None (Skip this section)

- ☐ Depression
- ☐ Anxiety
- ☐ PTSD
- ☐ Bipolar I
- ☐ Bipolar II
- ☐ Obsessive Compulsive Disorder
- ☐ Other mental health conditions not listed:
- ☐ Schizoaffective Disorder
- ☐ ADD/ADHD
- ☐ Autism Spectrum Disorder
- ☐ Eating Disorder
- ☐ Substance Use Disorder (sober or currently using)
- ☐ Alcoholism (sober or currently using)

_____

Allergies

What are your allergies and what is your reaction? ☐ None (Skip this section)

Medications _____ ☐ None
Foods _____ ☐ None
Animals/Insects _____ ☐ None

If your allergic reaction is anaphylaxis, do you have an epi-pen? ☐ Yes ☐ No

Date: _____

Name (to be called) _____Name Listed with Insurance (if different):_____

Pronoun_____ Birthdate _____

Medications

What medicines (prescription and over-the-counter), vitamins, supplements and herbs do you take (regularly and as needed)? ☐ None (Skip this section)

Name	*Dose*	*How often?*	*What is it for?*

Do you often have trouble remembering to take medicines? ☐ Yes ☐ No

Medical History of Blood Relatives

To your knowledge, have any of your blood relatives had any of the following? If so, please indicate who of your blood relatives has the condition. ☐ None ☐ Unknown (Skip this section)

☐ Diabetes	_____	☐ Sickle Cell Anemia	_____	☐ Blood Clots	_____
☐ High Cholesterol	_____	☐ Osteoporosis	_____	☐ Breast Cancer	_____
☐ High Blood Pressure	_____	☐ Parkinson's Disease	_____	☐ Cervical Cancer	_____
☐ Heart Attack	_____	☐ Alzheimer's Disease	_____	☐ Ovarian Cancer	_____
☐ Stroke	_____	☐ Mental health issues	_____	☐ Colon Cancer	_____
☐ Heart Surgery	_____	☐ Alcoholism	_____	☐ Prostate Cancer	_____
☐ Thalassemia	_____	☐ Drug User	_____	☐ Thyroid Condition	_____

☐ Not Listed:_____

Surgical History

What surgeries have you had in the past and in what year? ☐ None (Skip this section)

☐ Appendix removal	_____	☐ Breast Reduction	_____	☐ Breast Implants	_____
☐ Tonsils removal	_____	☐ Mastectomy	_____	☐ Orchiectomy	_____
☐ Hernia repair	_____	☐ Hysterectomy	_____	☐ Vulvoplasty	_____
☐ Gall bladder removal	_____	☐ Oopherectomy	_____	☐ Vaginoplasty	_____
☐ Orthopedic	_____	☐ Metoidioplasty	_____	☐ Tracheal Shave	_____
☐ Breast lumpectomy	_____	☐ Phalloplasty	_____	☐ Facial Surgery	_____
☐ Unilateral mastectomy	_____	☐ Scrotoplasty	_____	☐ Body Contouring	_____

☐ Not Listed:_____

Have you ever injected or pumped silicone, oils, or other substances for the purpose of body shaping? ☐ Yes ☐ No

Hospitalizations

Other than for surgery or childbirth, have you ever been hospitalized overnight for a medical or mental health issue? ☐ Yes ☐ No

If yes, what for and when?_____

_____

_____

Date: _____

Name (to be called) _____Name Listed with Insurance (if different):_____

Pronoun_____ Birthdate _____

Vaccinations

Did you receive childhood vaccinations?	☐ No	☐ I'm not sure	☐ Yes
Have you been vaccinated for:		**Approximate Date**	
HPV (Gardasil)	☐ No	_____	☐ Yes
Tetanus / TdaP	☐ No	_____	☐ Yes
Hepatitis A	☐ No	_____	☐ Yes
Hepatitis B	☐ No	_____	☐ Yes
Influenza (Flu)	☐ No	_____	☐ Yes
Pneumonia (Pneumovax)	☐ No	_____	☐ Yes
Chicken pox (Varavax)	☐ No	_____	☐ Yes
Shingles (Zostavax)	☐ No	_____	☐ Yes
Meningitis	☐ No	_____	☐ Yes
COVID-19	☐ No	_____	☐ Yes

When was the last time you had a test for tuberculosis (TB)? _____

What was the result?_____

Have you ever had a positive test for TB?	☐ Yes	☐ Unsure	☐ No
If yes, did you complete ≥ 6 months of preventative treatment?	☐ No	☐ Unsure	☐ Yes

Are you experiencing any of the following symptoms?

☐ cough > 3 weeks ☐ unexplained weight loss

☐ coughing up blood ☐ drenching night sweats

Have you had known contact with someone known to have TB disease of the lung?	☐ Yes	☐ No
Were you born in Asia, Africa, Latin America or Eastern Europe?	☐ Yes	☐ No
Have you spent more than 2 weeks in Asia, Africa, Latin America, or Eastern Europe in the past 2 years?	☐ Yes	☐ No
Have you been in prison/jail in the past 5 years?	☐ Yes	☐ No
Do you work with people who use drugs, are migrant workers, or are experiencing homelessness?	☐ Yes	☐ No
Are you a health care worker?	☐ Yes	☐ No

Sexual Health & Cancer Screenings

When was your last:			**Date**	**Result**	
Cervical Pap Smear	☐ never	☐ unsure			☐ Not applicable
Anal Pap Smear	☐ never	☐ unsure			☐ Not applicable
HIV Test	☐ never	☐ unsure			☐ Not applicable
Sexually Transmitted Infection Test	☐ never	☐ unsure			☐ Not applicable
Hepatitis C Test	☐ never	☐ unsure			☐ Not applicable
Mammogram	☐ never	☐ unsure			☐ Not applicable
Colorectal Cancer Screening	☐ never	☐ unsure			☐ Not applicable
Bone Density Scan	☐ never	☐ unsure			☐ Not applicable
Cholesterol Lab Test	☐ never	☐ unsure			☐ Not applicable

Have you ever been diagnosed with or tested positive for a sexually transmitted infection? ☐ No (Skip this section)

If yes, please check all that apply:

☐ HIV/AIDS	☐ Syphilis	☐ Trichomonas
☐ Gonorrhea	☐ Oral Herpes	☐ Bacterial Vaginosis
☐ Chlamydia	☐ Genital Herpes	☐ Yeast Infection
☐ Pelvic Inflammatory Disease	☐ Genital Warts	☐ Molluscum
☐ Not Listed: _____		

Name (to be called) _____Name Listed with Insurance (if different):_____
Pronoun_____ Birthdate _____

How would you describe your sexuality? (Check all that apply)

- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Queer
- ☐ Pansexual
- ☐ Heterosexual (Straight)
- ☐ Not Listed: _____
- ☐ Dyke
- ☐ Faggot
- ☐ Same Gender Loving
- ☐ Asexual (Ace)
- ☐ Aromantic (Aro)
- ☐ Demisexual
- ☐ BDSM/Kink
- ☐ Skoliosexual
- ☐ T4T (trans for trans)
- ☐ Questioning
- ☐ I don't use labels

When was the last time you had sex or came in contact with another person's bodily fluids?
(ejaculate, discharge, blood, or mucous membranes of the mouth, anus, genitals)
_____ ☐ Not applicable

What is your relationship status?
☐ Polyamorous ☐ Non-monogamous ☐ Monogamous ☐ Single, Dating ☐Single, Not Dating

How many regular sexual partner(s) do you currently have? _____ ☐ None

In the past year, how many different sexual partner(s) have you had? _____ ☐ None

What is the gender of your sexual partner(s)? (Check all that apply)
☐ Cis-gender Women ☐ Trans Feminine ☐ Non-Binary
☐ Cis-gender Men ☐ Trans Masculine ☐ Not Listed:_____

How do you practice "safer sex"?_____

As far as you're aware, do any of your sexual partners have a chronic sexually transmitted infection? (HIV, Genital Warts or HPV, Herpes) ☐ Yes ☐ No

Do you think you or your sexual partner(s) may have a contracted a new sexually transmitted infection recently? ☐ Yes ☐ No

Are you having any difficulties with your sex life? ☐ Yes ☐ No

Have you ever had a menstrual period? ☐ Unsure ☐Yes ☐ No (Skip this section)

How old were you when you first got your period? _____

Do you still have regular periods? ☐ Unsure ☐Yes ☐ No

If no, are you on any medications that stop or affect your period (such as hormones)? ☐ Unsure ☐No ☐ Yes (Skip this section)

What was the date that your last normal period began? _____

What are your periods like?

I get one every _____ days
It lasts for _____ days
On my heaviest day, I use _____ pads/tampons/cups
If you get cramps, how severe are they on a scale of 1 (low) to 10 (high)?_____

Are you capable or have you ever been capable of becoming pregnant? ☐ Yes ☐ No (Skip this section)

Have you ever been pregnant? ☐ Yes ☐ No

If yes, how many times have you:

Been Pregnant? ____ Had an abortion? ____ Had a miscarriage? ____
Had a premature birth? ____ Had a full-term birth? ____ How many live children do you have? ____

Are you planning on getting pregnant in the future? ☐ Unsure ☐ Yes ☐ No

Do you or your partner(s) use any kind of birth control? ☐ Not needed ☐ No ☐ Yes

If yes, what kind? _____ Are you satisfied with this method? ☐ No ☐ Yes

Could you be pregnant today? ☐ Yes ☐ No

Name (to be called) _____Name Listed with Insurance (if different):_____
Pronoun_____ Birthdate _____

Have you or are you currently going through menopause? ☐ Unsure ☐Yes ☐ No (Skip this section)

At what age? _____
Have you had any bleeding since then? ☐ Yes ☐ No
Are you currently having any symptoms of menopause? ☐ Yes ☐ No
If yes, which ones? ☐ Hot flashes ☐ Mood changes
☐ Insomnia ☐ Genital Dryness/Pain with penetration
☐ Not Listed: _____

Mental Health & Substance Use Screening

We ask all clients about safety, mental health, and substance use, because this can greatly affect your overall health.

Over the past <u>two weeks</u>, how often have you been bothered by:

Feeling nervous, anxious or on edge?
☐ Nearly every day ☐ More than half the days ☐ Several Days ☐ Not at all

Not being able to stop or control worrying?
☐ Nearly every day ☐ More than half the days ☐ Several Days ☐ Not at all

Have you ever been non-consensually hit, slapped, kicked, or physically hurt? ☐ Yes ☐ No
If yes, when did this happen? _____
Have you ever been forced or pressured to have sex? ☐ Yes ☐ No
If yes, when did this happen? _____
Do you want to discuss this with your provider today? ☐ Yes ☐ No

Over the past <u>two weeks</u>, how often have you been bothered by:

Having little interest or pleasure in doing things you usually enjoy?
☐ Nearly every day ☐ More than half the days ☐ Several Days ☐ Not at all

Feeling down, depressed, or hopeless?
☐ Nearly every day ☐ More than half the days ☐ Several Days ☐ Not at all

Do you often have trouble sleeping?
☐ Nearly every day ☐ More than half the days ☐ Several Days ☐ Not at all

The following are symptoms that people sometimes have after experiencing, witnessing or being confronted with a traumatic event. Please answer according to how much the symptoms have bothered you since the trauma.

Recurrent thoughts or memories of the event.
☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Not at all

Feeling as though the event is happening again.
☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Not at all

Recurrent nightmares about the event.
☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Not at all

Sudden emotional or physical reactions when reminded of the event.
☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Not at all

Avoiding activities that remind you of the event.
☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Not at all

Avoiding thoughts or feelings associated with the event.
☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Not at all

Feeling jumpy or easily startled.
☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Not at all

Feeling on guard.
☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Not at all

Name (to be called) _____Name Listed with Insurance (if different):_____
Pronoun_____ Birthdate _____

Do you currently use or have you ever used tobacco products? ☐ Yes ☐ No (Skip this section)

If yes, in terms of tobacco use, are you a:

- ☐ Current cigarette smoker
  - When did you first start smoking? _____
  - How many cigarettes do you smoke per day? _____
  - Are you interested in quitting? ☐ No ☐ Thinking about quitting ☐ Ready to quit
- ☐ Former cigarette smoker
  - When did you quit smoking? _____
  - On average how many cigarettes did you smoke per day? _____
  - How many years did you smoke for? _____
- ☐ Other tobacco user (Circle: cigars, hookah, chew, vape). How often and for how many years?_____

How many times in the past year have you had 4 or more alcoholic drinks in 1 day? _____ ☐ None (Skip this section)

Are you interested in quitting? ☐ No ☐ Thinking about Quitting ☐ Ready to Quit

How many times in the past year have you used a recreational or prescription drug for non-medical reasons? _____ ☐ None (Skip this section)

What have you used and when did you last use?

☐ Marijuana	_____	☐ Methamphetamines (Crystal Meth)	_____
☐ Rx Opioids (Fentanyl, Codeine, Oxycontin, Vicodin, Percocet, Dilaudid, Morphine, etc)	_____	☐ Rx Stimulants (Ritalin, Adderall, Dexedrine, Concerta, etc)	_____
☐ Heroin	_____	☐ Ketamine (Special K)	_____
☐ Cocaine/Crack	_____	☐ Barbiturates (Phenobarbitol)	_____
☐ Cathinones (Bath Salts)	_____	☐ Sleeping Aids (Ambien, Lunesta, etc)	_____
☐ MDMA (Ecstasy)	_____	☐ Rohypnol (GHB)	_____
☐ Phencyclidine (PCP)	_____	☐ LSD (Acid)	_____
☐ Anabolic Steroids or Human Growth Hormone	_____	☐ Mushrooms	_____
☐ Benzodiazepines (Xanax, Klonopin, Ativan, etc)	_____	☐ DMT (Ayahuasca)	_____
☐ Nitrous Oxide (Whippits)	_____	☐ Peyote (Mescaline)	_____
☐ Alkyl Nitrites (Poppers)	_____	☐ Not Listed:_____	_____

If you use opioids, do you have access to Narcan (Naloxone)? ☐ Not Applicable ☐ No ☐ Yes

Are you interested in quitting? ☐ No ☐ Thinking about Quitting ☐ Ready to Quit

Nutrition & Exercise

How many servings per day do you eat:

Fruit? _____ Vegetables? _____ Foods with calcium? _____
(milk, cheese, yogurt, soy milk, tofu, quinoa, greens, etc)

How easy is it for you to access these foods?

☐ Very difficult ☐ Somewhat difficult ☐ Easy

How many times per week do you consume the following:

Fast food? _____ Fried food? _____ Sugary drinks? _____

Do you feel like you eat the right amount of food? ☐ Too little ☐ Too much ☐ The right amount

Are you concerned about your weight? ☐ Yes ☐ No

Do you exercise? ☐ No ☐ Yes

If yes, what do you do? _____

How many times per week? _____How long do you spend working out at a time? _____

Date: _____

Name (to be called) _____Name Listed with Insurance (if different):_____

Pronoun_____ Birthdate _____

Dental History

Have you seen a dentist in the last 6 months?	☐ No	☐ Yes
Do you have difficulty chewing or swallowing?	☐ Yes	☐ No
Do you brush your teeth daily?	☐ No	☐ Yes
Do you floss daily?	☐ No	☐ Yes

Health Directive

Do you have a California Health Care Directive? (a legal document that specifies what actions should be taken if you are no longer able to make decisions for yourself)	☐ No	☐ Yes
Do you have someone to call if you need help in an emergency?	☐ No	☐ Yes
If over 50, do you have someone to help you make decisions about your health?	☐ No	☐ Yes

Employment, Housing, & Transportation

Are you working or in school? (Check all that apply)

- ☐ Yes, my current job is: _____
- ☐ No, I'm unemployed
- ☐ No, I'm retired
- ☐ No, I'm on disability for: _____
- ☐ Yes, I'm in school for: _____

What is your current living situation?

- ☐ House or Apartment (Stable/Permanent)
- ☐ With friends/family (Temporary)
- ☐ In a Single Room Occupancy (SRO) Hotel since _____
- ☐ In a Residential Treatment Program
- ☐ In a Vehicle
- ☐ In a Shelter
- ☐ On the Street

Who do you live with? _____

Do you feel safe in your living situation?	☐ No	☐ Yes
If you are over 50 and/or disabled, do you sometimes fall? Is it hard to get up?	☐ Yes	☐ No
Are there guns in your home?	☐ Yes	☐ No
Do you, your friends, or your family smoke in your home or place you live?	☐ Yes	☐ No
Are there working smoke detectors in your home?	☐ No	☐ Yes
Are you a primary caretaker for children, your parents or other adults?	☐ Yes	☐ No
Do you have any pets or a support animal?	☐ Yes	☐ No
When in a car, do you wear a seatbelt?	☐ No	☐ Yes
When riding a motorcycle, do you wear a helmet?	☐ No	☐ Yes
When riding a bicycle, do you wear a helmet?	☐ No	☐ Yes
Have you had any transportation-related accidents recently?	☐ Yes	☐ No
Are family members/friends worried about you driving?	☐ Yes	☐ No

Gender History

Are you trans, gender non-conforming or have a history of gender transition? ☐ Yes ☐ No (Skip this section)

How would you describe your gender identity? (Check all that apply):

- ☐ Woman
- ☐ Man
- ☐ MTF
- ☐ FTM
- ☐ Trans Feminine
- ☐ Trans Masculine
- ☐ Transguy
- ☐ Feminine-of-Center
- ☐ Masculine-of-Center
- ☐ T-Girl
- ☐ T-Boy
- ☐ Trans
- ☐ Transgender
- ☐ Transsexual
- ☐ Femme
- ☐ Butch
- ☐ Stud
- ☐ Aggressive (AG)
- ☐ Boi
- ☐ Androgynous
- ☐ Demigirl
- ☐ Demiboy
- ☐ Tomboy
- ☐ Two-Spirit
- ☐ Hijra
- ☐ Kathoey
- ☐ Muxe
- ☐ Khanith
- ☐ Gender Non-Conforming
- ☐ Genderqueer
- ☐ Gender Variant
- ☐ Gender Fluid
- ☐ Non-Binary
- ☐ Genderfuck
- ☐ Bi-Gender
- ☐ Multi-Gender
- ☐ Pangender
- ☐ Gender Creative
- ☐ Gender Expansive
- ☐ Third Gender
- ☐ Agender/Neutrois
- ☐ Questioning
- ☐ Don't use labels

Name (to be called) _____Name Listed with Insurance (if different):_____
Pronoun_____ Birthdate _____
☐ Not Listed:_____
_____

At what age did you first feel your gender identity differed from the gender that's assumed to align with the sex you were assigned at birth? _____

Have you ever felt anxious, distressed, depressed, or suicidal because your physical appearance did/does not align with your gender identity? ☐ Yes ☐ No

Are the following people aware of and supportive of your transition/gender identity and expression?

Significant other(s)	☐ Aware	☐ Supportive
Family of origin	☐ Aware	☐ Supportive
Support group	☐ Aware	☐ Supportive
Friends	☐ Aware	☐ Supportive
Therapist	☐ Aware	☐ Supportive
School	☐ Aware	☐ Supportive
Employer	☐ Aware	☐ Supportive

Do you have any fears about coming out as or being trans, non-binary, or gender non-conforming? What are they?

_____

Have you updated your name and/or gender marker on all identity documents you want to change? ☐ No ☐ Yes (Skip to next question)

If no, do you want assistance updating any of your identity documents? ☐ Yes ☐ No (Skip to next question)

If yes, which documents would you like to update?

- ☐ Social Security Card
- ☐ Driver's License or State-Issued ID
- ☐ Passport
- ☐ Green Card
- ☐ Birth Certificate (if checked, please tell us which state you were born in)_____

What would you like to change?

- ☐ Name only
- ☐ Gender Marker only (will need doctor's letter to change federal identity documents)
- ☐ Name and Gender Marker (will need doctor's letter to change federal identity documents)

Do you use any prosthetics or compression techniques to express your gender?
(bind, pack, breast forms, padding, tuck, etc.) ☐ Yes ☐ No (Skip to next question)

If yes,

How many hours per day? _____
What do you use? (binder, duct tape, KT tape, ace bandage, gaffe, packer, breast forms, tissue paper, socks, etc.)
_____
Do you have any complications? (chronic pain, urinary tract infections (UTIs), fungal infections, rashes, acne, broken bones, etc.)
_____

Name (to be called) _____Name Listed with Insurance (if different):_____
Pronoun_____ Birthdate _____

Have you ever discussed medical transition (hormone therapy and/or surgery) with a health care provider before? ☐ Yes ☐ No or N/A (Skip to next question)

If yes, when were you first diagnosed with gender dysphoria?_____
What clinic or provider diagnosed you?_____

If you are currently on hormone therapy,

When did you first start hormone therapy? _____
What is the current formulation and dose of your medication?
Medication (example: testosterone cypionate 200mg/mL):_____
Route (example: Injection, Patch, Gel, Pill):_____
Dose (example: 0.3mL):_____
How often (example: every week):_____
Do you have any concerns or issues with hormone therapy you would like to discuss?
_____

If you are not currently taking hormones,

Were you on hormones therapy in the past? ☐ Yes ☐ No
Are you interested in starting or re-starting hormone therapy? ☐ Yes ☐ No
If yes, what are you hoping hormones will do for you?
_____
If yes, what (if any) are your concerns about taking hormones?
_____

Are you interested in pursuing any gender affirming surgeries? ☐ Yes ☐ No (Skip this question)

If yes, which surger(ies)? (Check all that apply)

- ☐ Mastectomy (top surgery)
- ☐ Hysterectomy (removal of uterus)
- ☐ Oophorectomy (removal of ovaries)
- ☐ Metoidioplasty
- ☐ Vaginectomy
- ☐ Urethral Lengthening
- ☐ Scrotoplasty
- ☐ Phalloplasty
- ☐ Breast Augmentation (implants)
- ☐ Orchiectomy (removal of testes)
- ☐ Vulvoplasty
- ☐ Vaginoplasty
- ☐ Tracheal Shave (adam's apple reduction)
- ☐ Facial Hair Reduction (laser or electrolysis)
- ☐ Facial Gender Confirmation Surgery
- ☐ Body Contouring
- ☐ Not Listed: _____

Thank you for taking the time to complete this form!